108TH CONGRESS
1ST SESSION

S. 100

To expand access to affordable health care and to strengthen the health care safety net and make health care services more available in rural and underserved areas.

IN THE SENATE OF THE UNITED STATES

JANUARY 7, 2003

Ms. COLLINS (for herself and Ms. LANDRIEU) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To expand access to affordable health care and to strengthen the health care safety net and make health care services more available in rural and underserved areas.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Access to Affordable Health Care Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—EXPANSION OF ACCESS TO AFFORDABLE HEALTH CARE FOR SMALL BUSINESSES

Subtitle A—Small Business Tax Credit

SEC. 101. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following:

"SEC. 45G. EMPLOYEE HEALTH INSURANCE EXPENSES.

''(a) GENERAL RULE.—For purposes of section 38, in the case of an employer, the employee health insurance expenses credit determined under this section is an amount equal to the applicable percentage of the amount paid by the taxpayer during the taxable year for qualified employee health insurance expenses.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage is equal to—

''(1) 50 percent in the case of an employer with less than 10 employees, and

''(2) 30 percent in the case of an employer with more than 9 but less than 26 employees.

''(c) PER EMPLOYEE DOLLAR LIMITATION.—The amount of qualified employee health insurance expenses taken into account under subsection (a) with respect to any qualified employee for any taxable year shall not exceed—

''(1) $2,000 in the case of self-only coverage, and

''(2) $4,000 in the case of family coverage (as so defined).

''(d) SPECIAL RULES AND DEFINITIONS.—For purposes of this section—

''(1) ELIGIBILITY FOR CREDIT.—No credit shall be allowed under subsection (a) with respect to any employer which, with respect to the number of employees employed during any period, employs more than 20 percent of highly compensated employees (within the meaning of section 414(q)).

''(2) DETERMINATION OF EMPLOYMENT.—

''(A) IN GENERAL.—An employer shall be considered an employer described in paragraph (1) or (2) of subsection (b) if such employer

employed an average of the number of employees described in such paragraph on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(3) QUALIFIED EMPLOYEE HEALTH INSURANCE EXPENSES.—

''(A) IN GENERAL.—The term 'qualified employee health insurance expenses' means any amount paid by an employer for health insurance coverage to the extent such amount—

''(i) is attributable to coverage provided to any employee while such employee is a qualified employee; and

"(ii) is at least 50 percent of the premium for such coverage.

"(B) EXCEPTION FOR AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account under subparagraph (A).

"(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1).

"(4) QUALIFIED EMPLOYEE.—

"(A) IN GENERAL.—The term 'qualified employee' means, with respect to any period, an employee of an employer if the total amount of wages paid or incurred by such employer to such employee at an annual rate during the taxable year is not less than $5,000.

"(B) TREATMENT OF CERTAIN EMPLOYEES.—For purposes of subparagraph (A), the term 'employee'—

"(i) shall not include an employee within the meaning of section 401(c)(1), but

''(ii) shall include a leased employee within the meaning of section 414(n).

''(C) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

''(e) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

''(f) DENIAL OF DOUBLE BENEFIT.—No deduction or credit under any other provision of this chapter shall be allowed with respect to qualified employee health insurance expenses taken into account under subsection (a).''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ''plus'' at the end of paragraph (14), by striking the period at the end of paragraph (15) and inserting '', plus'', and by adding at the end the following:

''(16) the employee health insurance expenses credit determined under section 45G.''.

(c) NO CARRYBACKS.—Subsection (d) of section 39 of the Internal Revenue Code of 1986 (relating to carryback and carryforward of unused credits) is amended by adding at the end the following:

''(11) NO CARRYBACK OF SECTION 45G CREDIT BEFORE EFFECTIVE DATE.—No portion of the unused business credit for any taxable year which is attributable to the employee health insurance expenses credit determined under section 45G may be carried back to a taxable year ending before January 1, 2003.''.

(d) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 45G. Employee health insurance expenses.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2002.

Subtitle B—Grants to States for Small Business Purchasing Groups

SEC. 121. GRANTS FOR SMALL EMPLOYER PURCHASING GROUPS.

(a) IN GENERAL.—The Secretary of Labor (referred to in this section as the ''Secretary'') shall award grants to States to assist such States in planning, developing, and operating qualified small employer purchasing groups.

(b) APPLICATION REQUIREMENTS.—To be eligible to receive a grant under this section, a State shall prepare and submit to the Secretary an application in such form,

at such time, and containing such information, certifications, and assurances as the Secretary shall reasonably require.

(c) USE OF FUNDS.—Amounts awarded under this section may be used to finance the costs associated with planning, developing, and operating a qualified small employer purchasing group that meets the requirements of section 122. Such costs may include the costs associated with—

(1) engaging in education and outreach efforts to inform small employers, insurers, and the public about the small employer purchasing group;

(2) soliciting bids and negotiating with insurers to make available group health plans;

(3) preparing the documentation required to receive certification by the Secretary as a qualified small employer purchasing group; and

(4) such other activities determined appropriate by the Secretary.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2004 through 2008.

SEC. 122. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

(a) QUALIFIED SMALL EMPLOYER PURCHASING GROUPS DESCRIBED.—

(1) IN GENERAL.—A qualified small employer purchasing group is an entity that—

(A) is a nonprofit entity certified under State law;

(B) has a membership consisting solely of small employers;

(C) is administered solely under the authority and control of its member employers;

(D) with respect to each State in which its members are located, consists of not fewer than the number of small employers established by the State as appropriate for such a group;

(E) offers a program under which group health plans are offered to eligible employees and eligible individuals (including the dependents of such employees and individuals) through its member employers; and

(F) an insurer, agent, broker, or any other individual or entity engaged in the sale of insurance—

(i) does not form or underwrite; and

(ii) does not hold or control any right to vote with respect to.

(2) SPECIAL RULE.—Notwithstanding paragraph (1)(B), an employer member of a small employer purchasing group that has been certified by the State as meeting the requirements of paragraph (1) may retain its membership in the group if the number of employees of the employer increases such that the employer is no longer a small employer.

(b) BOARD OF DIRECTORS.—Each qualified small employer purchasing group established under this section shall be governed by a board of directors or have active input from an advisory board consisting of individuals and businesses participating in the group.

(c) MEMBERSHIP.—

(1) IN GENERAL.—A qualified small employer purchasing group shall accept all small employers residing within the area served by the group as members if such employers request such membership.

(2) VOTING.—Members of a qualified small employer purchasing group shall have voting rights consistent with the rules established by the State.

(d) DUTIES OF QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.—Each qualified small employer purchasing group shall—

(1) enter into agreements with insurers offering qualified group health plans;

(2) enter into agreements with small employers for the purchase of health insurance;

(3) enroll only eligible employees, eligible individuals, and the dependents of such employees and individuals in group health plans; and

(4) provide enrollee information to the State.

(e) LIMITATION ON ACTIVITIES.—A qualified small employer purchasing group shall not—

(1) perform any activity involving approval or enforcement of payment rates for providers;

(2) assume financial risk in relation to any such health plan; or

(3) perform other activities identified by the State as being inconsistent with the performance of its duties.

(f) RULES OF CONSTRUCTION.—

(1) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring that a State organize, operate or otherwise establish a qualified small employer purchasing group, or otherwise require the establishment of purchasing groups.

(2) VOLUNTARY PARTICIPATION.—Nothing in this section shall be construed as requiring any indi-

vidual or small employer to purchase a group health plan exclusively through a qualified small employer purchasing group.

(g) DEFINITION.—In this subtitle, the term ''small employer'' means an employer that employs at least 1, but not more than 50 employees. Such term shall include sole proprietorships and self-employed individuals.

Subtitle C—Health Benefits Information for Small Employers

SEC. 131. GRANT PROGRAM TO FACILITATE HEALTH BENEFITS INFORMATION FOR SMALL EMPLOYERS.

(a) IN GENERAL.—The Small Business Administration shall award grants to 1 or more States, local governments, and non-profit organizations for the purposes of—

(1) demonstrating new and effective ways to provide information about the benefits of health insurance to small employers, including tax benefits, increased productivity of employees, and decreased turnover of employees;

(2) making small employers aware of their current rights in the marketplace under Federal and State health insurance reform laws; and

(3) making small employers aware of the tax treatment of insurance premiums.

(b) AUTHORIZATION.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2004 through 2008.

Subtitle D—Grant Program to Encourage State Innovation

SEC. 141. GRANT PROGRAM TO ENCOURAGE STATE INNOVATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program (in this section referred to as the ''program'') to award demonstration grants under this section to States to allow States to demonstrate the effectiveness of innovative ways to increase access to health insurance through market reforms and other innovative means. Such innovative means may include any of the following:

(1) Alternative group purchasing or pooling arrangements, such as purchasing cooperatives for small businesses, reinsurance pools, or high risk pools.

(2) Individual or small group market reforms.

(3) Consumer education and outreach.

(4) Subsidies to individuals, employers, or both, in obtaining health insurance.

(b) SCOPE; DURATION.—The program shall be limited to not more than 10 States and to a total period of 5 years, beginning on the date the first demonstration grant is made.

(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary may not provide for a demonstration grant to a State under the program unless the Secretary finds that under the proposed demonstration grant—

(A) the State will provide for demonstrated increase of access for some portion of the existing uninsured population through a market innovation (other than merely through a financial expansion of a program initiated before the date of enactment of this Act);

(B) the State will comply with applicable Federal laws;

(C) the State will not discriminate among participants on the basis of any health status-related factor (as defined in section 2791(d)(9) of the Public Health Service Act (42 U.S.C. 300gg–91(d)(9)), except to the extent a State wishes to focus on populations that otherwise would not obtain health insurance because of such factors; and

(D) the State will provide for such evaluation, in coordination with the evaluation required under subsection (d), as the Secretary may specify.

(2) APPLICATION.—The Secretary shall not provide a demonstration grant under the program to a State unless—

(A) the State submits to the Secretary such an application, in such a form and manner, as the Secretary specifies;

(B) the application includes information regarding how the demonstration grant will address issues such as governance, targeted population, expected cost, and the continuation after the completion of the demonstration grant period; and

(C) the Secretary determines that the demonstration grant will be used consistent with this section.

(3) FOCUS.—A demonstration grant proposal under this section need not cover all uninsured individuals in a State or all health care benefits with respect to such individuals.

(d) EVALUATION.—The Secretary shall enter into a contract with an appropriate entity outside the Depart-

ment of Health and Human Services to conduct an overall evaluation of the program at the end of the program period. Such evaluation shall include an analysis of improvements in access, costs, quality of care, or choice of coverage, under different demonstration grants.

(e) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Notwithstanding the previous provisions of this section, under the program the Secretary may provide for a portion of the amounts appropriated under subsection (f) (not to exceed $5,000,000) to be made available to any State for initial planning grants to permit States to develop demonstration grant proposals under the previous provisions of this section.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) STATE DEFINED.—In this section, the term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

TITLE II—EXPANSION OF ACCESS TO AFFORDABLE HEALTH CARE FOR INDIVIDUALS AND FAMILIES

Subtitle A—Internal Revenue Code Provisions

CHAPTER 1—REFUNDABLE CREDIT FOR UNINSURED FAMILIES

SEC. 201. REFUNDABLE HEALTH INSURANCE COSTS CREDIT.

(a) ALLOWANCE OF CREDIT.—

(1) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable personal credits) is amended by redesignating section 36 as section 37 and inserting after section 35 the following:

"SEC. 36. HEALTH INSURANCE COSTS FOR UNINSURED ELIGIBLE INDIVIDUALS.

''(a) ALLOWANCE OF CREDIT.—In the case of an uninsured eligible individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the amount paid by the taxpayer during such taxable year for qualified health insurance for the taxpayer and the taxpayer's spouse and dependents.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the lesser of—

''(A) the sum of the monthly limitations for coverage months during such taxable year for the individuals referred to in subsection (a) for whom the taxpayer paid during the taxable year any amount for coverage under qualified health insurance, or

''(B) 90 percent of the amount paid by the taxpayer during such taxable year for qualified health insurance for such individuals.

''(2) MONTHLY LIMITATION.—

''(A) IN GENERAL.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12 of—

''(i) $1,000 if such individual is the taxpayer,

''(ii) $1,000 if—

''(I) such individual is the spouse of the taxpayer,

''(II) the taxpayer and such spouse are married as of the first day of such month, and

''(III) the taxpayer files a joint return for the taxable year, and

''(iii) $500 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

''(B) LIMITATION TO 2 DEPENDENTS.—Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (A)(iii).

''(C) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of an individual—

''(i) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

''(ii) who does not live apart from such individual's spouse at all times during the taxable year,

the limitation imposed by subparagraph (B) shall be divided equally between the individual and the individual's spouse unless they agree on a different division.

''(3) PHASEOUT OF CREDIT.—

''(A) IN GENERAL.—The amount which would (but for this paragraph) be taken into account under subsection (a) shall be reduced (but not below zero) by the amount determined under subparagraph (B).

''(B) AMOUNT OF REDUCTION.—The amount determined under this subparagraph is the amount which bears the same ratio to the amount which would be so taken into account for the taxable year as—

''(i) the excess of—

''(I) the taxpayer's modified adjusted gross income for the preceding taxable year, over

''(II) $15,000 ($25,000 in the case of family coverage), bears to

''(ii) $15,000 ($35,000 in the case of family coverage).

''(C) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income determined—

''(i) without regard to this section and sections 911, 931, and 933, and

''(ii) after application of sections 86, 135, 137, 219, 221, and 469.

''(4) COVERAGE MONTH.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'coverage month' means, with respect to an individual, any month if—

''(i) as of the first day of such month such individual is covered by qualified health insurance, and

''(ii) the premium for coverage under such insurance for such month is paid by the taxpayer.

''(B) EMPLOYER-SUBSIDIZED COVERAGE.—

''(i) IN GENERAL.—Such term shall not include any month for which such individual is eligible to participate in any subsidized health plan (within the meaning of section 162(l)(2)) maintained by any employer of the taxpayer or of the spouse of the taxpayer.

''(ii) PREMIUMS TO NONSUBSIDIZED PLANS.—If an employer of the taxpayer or the spouse of the taxpayer maintains a

health plan which is not a subsidized health plan (as so defined) and which constitutes qualified health insurance, employee contributions to the plan shall be treated as amounts paid for qualified health insurance.

''(C) CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT BENEFICIARIES.—Such term shall not include any month during a taxable year if any amount is not includible in the gross income of the taxpayer for such year under section 106 with respect to—

''(i) a benefit chosen under a cafeteria plan (as defined in section 125(d)), or

''(ii) a benefit provided under a flexible spending or similar arrangement.

''(D) MEDICARE AND MEDICAID.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual—

''(i) is entitled to any benefits under title XVIII of the Social Security Act, or

''(ii) is a participant in the program under title XIX or XXI of such Act.

"(E) CERTAIN OTHER COVERAGE.—Such term shall not include any month during a taxable year with respect to an individual if, at any time during such year, any benefit is provided to such individual under—

"(i) chapter 89 of title 5, United States Code,

"(ii) chapter 55 of title 10, United States Code,

"(iii) chapter 17 of title 38, United States Code, or

"(iv) any medical care program under the Indian Health Care Improvement Act.

"(F) PRISONERS.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

"(G) INSUFFICIENT PRESENCE IN UNITED STATES.—Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

''(5) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—In the case of a taxpayer who is eligible to deduct any amount under section 162(l) for the taxable year, this section shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' means health insurance coverage (as defined in section 9832(b)(1)), including coverage under a COBRA continuation provision (as defined in section 9832(d)(1)).

''(d) ARCHER MSA CONTRIBUTIONS.—If a deduction would be allowed under section 220 to the taxpayer for a payment for the taxable year to the Archer MSA of an individual, subsection (a) shall not apply to the taxpayer for such taxable year.

''(e) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

''(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(3) COORDINATION WITH ADVANCE PAYMENT.—Rules similar to the rules of section 32(g) shall apply to any credit to which this section applies.

''(f) EXPENSES MUST BE SUBSTANTIATED.—A payment for insurance to which subsection (a) applies may be taken into account under this section only if the taxpayer substantiates such payment in such form as the Secretary may prescribe.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050T the following:

"SEC. 6050U. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

"(a) IN GENERAL.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

"(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

"(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage,

"(C) the aggregate amount of payments described in subsection (a),

''(D) the qualified health insurance credit advance amount (as defined in section 7528(e)) received by such person with respect to the individual described in subparagraph (A), and

''(E) such other information as the Secretary may reasonably prescribe.

''(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 36(c)).

''(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished,

''(3) the information required under subsection (b)(2)(B) with respect to such payments, and

''(4) the qualified health insurance credit advance amount (as defined in section 7528(e)) received by such person with respect to the individual described in paragraph (2).

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xii) through (xviii) as clauses (xiii) through (xix), respectively, and by inserting after clause (xi) the following:

''(xii) section 6050U (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (AA), by striking the period at the end of the subparagraph (BB) and inserting '', or'', and by adding at the end the following:

''(CC) section 6050U(d) (relating to returns relating to payments for qualified health insurance).''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050T the following:

''Sec. 6050U. Returns relating to payments for qualified health insurance.''.

(c) CRIMINAL PENALTY FOR FRAUD.—Subchapter B of chapter 75 of the Internal Revenue Code of 1986 (relating to other offenses) is amended by adding at the end the following:

''SEC. 7276. PENALTIES FOR OFFENSES RELATING TO HEALTH INSURANCE TAX CREDIT.

''Any person who knowingly misuses Department of the Treasury names, symbols, titles, or initials to convey the false impression of association with, or approval or endorsement by, the Department of the Treasury of any in-

surance products or group health coverage in connection with the credit for health insurance costs under section 36 shall on conviction thereof be fined not more than $10,000, or imprisoned not more than 1 year, or both.''.

(d) CONFORMING AMENDMENTS.—

(1) Section 162(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) ELECTION TO HAVE SUBSECTION APPLY.—No deduction shall be allowed under paragraph (1) for a taxable year unless the taxpayer elects to have this subsection apply for such year.''.

(2) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36 of such Code''.

(3) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following:

''Sec. 36. Health insurance costs for uninsured eligible individuals.
''Sec. 37. Overpayments of tax.''.

(4) The table of sections for subchapter B of chapter 75 of such Code is amended by adding at the end the following:

''Sec. 7276. Penalties for offenses relating to health insurance tax credit.''.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2003, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

(2) PENALTIES.—The amendments made by subsections (c) and (d)(4) shall take effect on the date of the enactment of this Act.

SEC. 202. ADVANCE PAYMENT OF CREDIT TO ISSUERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following:

"SEC. 7528. ADVANCE PAYMENT OF HEALTH INSURANCE CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

''(a) GENERAL RULE.—Every plan sponsor of a group health plan providing, or qualified health insurance issuer of, qualified health insurance to an eligible individual shall—

''(1) make qualified premium payments with respect to such individual in an amount equal to the

qualified health insurance credit advance amount, and

''(2) treat such payments in the manner provided in subsection (g).

''(b) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual—

''(1) who purchases qualified health insurance (as defined in section 36(c)), and

''(2) for whom a qualified health insurance credit eligibility certificate is in effect.

''(c) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED HEALTH INSURANCE ISSUER.—The term 'qualified health insurance issuer' means a health insurance issuer described in section 9832(b)(2) (determined without regard to the last sentence thereof) offering coverage in connection with a group health plan.

''(2) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1) (determined without regard to subsection (d) thereof).

''(3) QUALIFIED PREMIUM PAYMENTS.—The term 'qualified premium payments' means any amount paid or incurred, cost incurred, or health

coverage value provided, with respect to qualified health insurance for an eligible individual and the individual's spouse and dependents. For purposes of the preceding sentence, in the case of a group health plan, the health coverage value is equal to the applicable premium under the plan for the qualified health insurance coverage provided to an eligible individual and the individual's spouse and dependents, as determined under section 4980B.

''(d) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to a plan sponsor of a group health plan or qualified health insurance issuer which—

''(1) certifies that the individual will be eligible to receive the credit provided by section 36 for the taxable year,

''(2) estimates the amount of such credit for such taxable year, and

''(3) provides such other information as the Secretary may require for purposes of this section.

''(e) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—For purposes of this section, the term 'qualified health insurance credit advance amount' means,

with respect to any plan sponsor of a group health plan providing, or qualified health insurance issuer of, qualified health insurance, the amount of credit allowable under section 36 to the individual for the taxable year which is attributable to the insurance provided to the individual by such sponsor or issuer.

''(f) REQUIRED DOCUMENTATION FOR RECEIPT OF PAYMENTS OF ADVANCE AMOUNT.—No payment of a qualified health insurance credit advance amount with respect to any eligible individual may be made under subsection (a) unless the plan sponsor of the group health plan or qualified health insurance issuer provides to the Secretary—

''(1) the qualified health insurance credit eligibility certificate of such individual, and

''(2) the return relating to such individual under section 6050U.

''(g) QUALIFIED PREMIUM PAYMENTS TO BE TREATED AS PAYMENTS OF WITHHOLDING AMOUNTS AND CERTAIN EMPLOYER TAX.—

''(1) IN GENERAL.—For purposes of this title, qualified premium payments made or costs incurred by the sponsor of a group health plan, or any entity designated by the sponsor to make such payments or incur such costs—

"(A) shall not be treated as compensation, and

"(B) shall be treated, in such manner as provided by the Secretary, as made out of—

"(i) amounts required to be deposited by the taxpayer as estimated income tax under section 6654 or 6655,

"(ii) amounts required to be deducted and withheld under section 3401 (relating to wage withholding),

"(iii) amounts of the taxes imposed under section 3111(a) or 50 percent of taxes imposed under section 1401(a) (relating to FICA employer taxes), or

"(iv) amounts required to be deducted under section 3102 with respect to taxes imposed under section 3101(a) or 50 percent of taxes imposed under section 1401(a) (relating to FICA employee taxes),

as if such sponsor, or such designated entity, had paid to the Secretary an amount equal to such payments.

"(2) QUALIFIED PREMIUM PAYMENTS EXCEED TAXES DUE.—In the case of any entity, if for any

time period the aggregate qualified premium payments exceed the amounts described in paragraph (1)(B), the Secretary shall reduce amounts described in such paragraph for any succeeding time period as necessary to reflect such excess.

''(3) FAILURE TO MAKE QUALIFIED PREMIUM PAYMENTS.—For purposes of this title (including penalties), failure to make a qualified premium payment with respect to an eligible individual at the time provided therefor shall be treated as the failure at such time to deduct and withhold under chapter 24 of such Code in an amount equal to the amount of such qualified premium payments.

''(h) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 7528. Advance payment of health insurance credit for purchasers of qualified health insurance.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2005, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

CHAPTER 2—IMMEDIATE, FULL DEDUCTIBILITY OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS

SEC. 205. DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.''.

(b) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of the Internal Revenue Code of 1986 is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer

(other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2002.

Subtitle B—FamilyCare

SEC. 211. RENAMING OF TITLE XXI PROGRAM.

(a) IN GENERAL.—The heading of title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended to read as follows:

''TITLE XXI—FAMILYCARE PROGRAM''.

(b) PROGRAM REFERENCES.—Any reference in any provision of Federal law or regulation to ''SCHIP'' or ''State children's health insurance program'' under title XXI of the Social Security Act shall be deemed a reference to the FamilyCare program under such title.

SEC. 212. FAMILYCARE COVERAGE OF PARENTS UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) INCENTIVES TO IMPLEMENT FAMILYCARE COVERAGE.—

(1) UNDER MEDICAID.—

(A) ESTABLISHMENT OF NEW OPTIONAL ELIGIBILITY CATEGORY.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(i) by striking ''or'' at the end of subclause (XVII);

(ii) by adding ''or'' at the end of subclause (XVIII); and

(iii) by adding at the end the following:

''(XIX) who are individuals described in subsection (k)(1) (relating to parents of categorically eligible children);''.

(B) PARENTS DESCRIBED.—Section 1902 of the Social Security Act is further amended by inserting after subsection (j) the following:

''(k)(1)(A) Individuals described in this paragraph are individuals—

''(i) who are the parents of an individual who is under 19 years of age (or such higher age as the State may have elected under section 1902(l)(1)(D)) and who is eligible for medical assistance under subsection (a)(10)(A);

''(ii) who are not otherwise eligible for medical assistance under such subsection, under section 1931, or under a waiver approved under section 1115 or otherwise (except under subsection (a)(10)(A)(ii)(XIX)); and

''(iii) whose family income exceeds the income level applicable under the State plan under part A of title IV as in effect as of July 16, 1996, but does not exceed the highest income level applicable to a child in the family under this title.

''(B) In establishing an income eligibility level for individuals described in this paragraph, a State may vary such level consistent with the various income levels established under subsection (l)(2) based on the ages of children described in subsection (l)(1) in order to ensure, to the maximum extent possible, that such individuals shall be enrolled in the same program as their children.

''(C) An individual may not be treated as being described in this paragraph unless, at the time of the individual's enrollment under this title, the child referred to in subparagraph (A)(i) of the individual is also enrolled under this title.

''(D) In this subsection, the term 'parent' includes an individual treated as a caregiver for purposes of carrying out section 1931.

''(2) In the case of a parent described in paragraph (1) who is also the parent of a child who is eligible for child health assistance under title XXI, the State may elect (on a uniform basis) to cover all such parents under section 2111 or under this title.''.

(C) ENHANCED MATCHING FUNDS AVAILABLE IF CERTAIN CONDITIONS MET.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(i) in the fourth sentence of subsection (b), by striking ''or subsection (u)(3)'' and inserting '', (u)(3), or (u)(4)''; and

(ii) in subsection (u)—

(I) by redesignating paragraph (4) as paragraph (6), and

(II) by inserting after paragraph (3) the following:

''(4) For purposes of subsection (b) and section 2105(a)(1):

''(A) FAMILYCARE PARENTS.—The expenditures described in this subparagraph are the expenditures described in the following clauses (i) and (ii):

''(i) PARENTS.—If the conditions described in clause (iii) are met, expenditures for medical assistance for parents described in section 1902(k)(1) and for parents who would be described in such section but for the fact that they are eligible for medical assistance under

section 1931 or under a waiver approved under section 1115.

''(ii) CERTAIN PREGNANT WOMEN.—Expenditures for medical assistance for pregnant women under section 1902(l)(1)(A) in a family the income of which exceeds the income level applicable under section 1902(l)(2)(A) to a family of the size involved as of January 1, 2003.

''(iii) CONDITIONS.—The conditions described in this clause are the following:

''(I) The State has a State child health plan under title XXI which (whether implemented under such title or under this title) has an effective income level for children that is at least 200 percent of the poverty line.

''(II) Such State child health plan does not limit the acceptance of applications, does not use a waiting list for children who meet eligibility standards to qualify for assistance, and provides benefits to all children in the State who apply for and meet eligibility standards.

"(III) The State plans under this title and title XXI do not provide coverage for parents with higher family income without covering parents with a lower family income.

"(IV) The State does not apply an income level for parents that is lower than the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of January 1, 2003, to be eligible for medical assistance as a parent under this title.

"(iv) DEFINITIONS.—For purposes of this subsection:

"(I) The term 'parent' has the meaning given such term for purposes of section 1902(k)(1).

"(II) The term 'poverty line' has the meaning given such term in section 2110(c)(5).".

(D) APPROPRIATION FROM TITLE XXI ALLOTMENT FOR CERTAIN MEDICAID EXPANSION

COSTS.—Subparagraph (B) of section 2105(a)(1) of the Social Security Act, as amended by section 217(a), is amended to read as follows:

''(B) FAMILYCARE PARENTS.—Expenditures for medical assistance that is attributable to expenditures described in section 1905(u)(4)(A).''.

(E) ONLY COUNTING ENHANCED PORTION FOR COVERAGE OF ADDITIONAL PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(i) in the fourth sentence of subsection (b), by inserting ''(except in the case of expenditures described in subsection (u)(5))'' after ''do not exceed''; and

(ii) in subsection (u), by inserting after paragraph (4) (as inserted by subparagraph (C)), the following:

''(5) For purposes of the fourth sentence of subsection (b) and section 2105(a), the following payments under this title do not count against a State's allotment under section 2104:

''(A) REGULAR FMAP FOR EXPENDITURES FOR PREGNANT WOMEN WITH INCOME ABOVE JANUARY

1, 2003 INCOME LEVEL AND BELOW 185 PERCENT OF POVERTY.—The portion of the payments made for expenditures described in paragraph (4)(A)(ii) that represents the amount that would have been paid if the enhanced FMAP had not been substituted for the Federal medical assistance percentage.''.

(2) UNDER TITLE XXI.—

(A) FAMILYCARE COVERAGE.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. OPTIONAL FAMILYCARE COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN.

''(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State child health plan may provide for coverage, through an amendment to its State child health plan under section 2102, of FamilyCare assistance for individuals who are targeted low-income parents in accordance with this section, but only if—

''(1) the State meets the conditions described in section 1905(u)(4)(A)(iii); and

''(2) the State elects to provide medical assistance under section 1902(a)(10)(A)(ii)(XIX), under section 1931, or under a waiver under section 1115 to individuals described in section 1902(k)(1)(A)(i)

and elects an applicable income level for such individuals that consistent with paragraphs (1)(B) and (2) of section 1902(k), ensures to the maximum extent possible, that those individuals shall be enrolled in the same program as their children if their children are eligible for coverage under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)).''.

''(b) DEFINITIONS.—For purposes of this title:

''(1) FAMILYCARE ASSISTANCE.—The term 'FamilyCare assistance' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income parents.

''(2) TARGETED LOW-INCOME PARENT.—The term 'targeted low-income parent' has the meaning given the term targeted low-income child in section 2110(b) as if the reference to a child were deemed a reference to a parent (as defined in paragraph (3)) of the child; except that in applying such section—

''(A) there shall be substituted for the income level described in paragraph (1)(B)(ii)(I) the applicable income level in effect for a targeted low-income child;

"(B) in paragraph (3), January 1, 2003, shall be substituted for July 1, 1997; and

"(C) in paragraph (4), January 1, 2003, shall be substituted for March 31, 1997.

"(3) PARENT.—The term 'parent' includes an individual treated as a caregiver for purposes of carrying out section 1931.

"(4) OPTIONAL TREATMENT OF PREGNANT WOMEN AS PARENTS.—A State child health plan may treat a pregnant woman who is not otherwise a parent as a targeted low-income parent for purposes of this section but only if the State has established an income level under section 1902(l)(2)(A)(i) for pregnant women that is at least 185 percent of the income official poverty line described in such section.

"(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of FamilyCare assistance to targeted low-income parents under subsection (a), the following special rules apply:

"(1) Any reference in this title (other than subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income parent.

''(2) Any such reference to child health assistance with respect to such parents is deemed a reference to FamilyCare assistance.

''(3) In applying section 2103(e)(3)(B) in the case of a family provided coverage under this section, the limitation on total annual aggregate cost-sharing shall be applied to the entire family.

''(4) In applying section 2110(b)(4), any reference to 'section 1902(l)(2) or 1905(n)(2) (as selected by a State)' is deemed a reference to the income level applicable to parents under section 1931 or under a waiver approved under section 1115, or, in the case of a pregnant woman described in subsection (b)(4), the income level established under section 1902(l)(2)(A).

''(5) In applying section 2102(b)(3)(B), any reference to children is deemed a reference to parents.''.

(B) ADDITIONAL ALLOTMENT FOR STATES PROVIDING FAMILYCARE.—

(i) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by inserting after subsection (c) the following:

"(d) ADDITIONAL ALLOTMENTS FOR STATE PROVIDING FAMILYCARE.—

"(1) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing additional allotments to States to provide FamilyCare coverage under section 2111, there is appropriated, out of any money in the Treasury not otherwise appropriated—

"(A) for fiscal year 2004, $2,000,000,000;

"(B) for fiscal year 2005, $3,000,000,000;

"(C) for fiscal year 2006, $3,000,000,000;

"(D) for fiscal year 2007, $6,000,000,000;

"(E) for fiscal year 2008, $7,000,000,000;

"(F) for fiscal year 2009, $8,000,000,000;

"(G) for fiscal year 2010, $9,000,000,000;

"(H) for fiscal year 2011, $10,000,000,000; and

"(I) for fiscal year 2012 and each fiscal year thereafter, the amount of the allotment provided under this paragraph for the preceding fiscal year increased by the percentage increase (if any) in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average).

"(2) STATE AND TERRITORIAL ALLOTMENTS.—

''(A) IN GENERAL.—In addition to the allotments provided under subsections (b) and (c), subject to paragraphs (3) and (4), of the amount available for the additional allotments under paragraph (1) for a fiscal year, the Secretary shall allot to each State with a State child health plan approved under this title—

''(i) in the case of such a State other than a commonwealth or territory described in clause (ii), the same proportion as the proportion of the State's allotment under subsection (b) (determined without regard to subsection (f)) to 98.95 percent of the total amount of the allotments under such section for such States eligible for an allotment under this subparagraph for such fiscal year; and

''(ii) in the case of a commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth's or territory's allotment under subsection (c) (determined without regard to subsection (f)) to 1.05 percent of the total amount of the allotments under such section for commonwealths and terri-

tories eligible for an allotment under this subparagraph for such fiscal year.

''(B) AVAILABILITY AND REDISTRIBUTION OF UNUSED ALLOTMENTS.—In applying subsections (e) and (f) with respect to additional allotments made available under this subsection, the procedures established under such subsections shall ensure such additional allotments are only made available to States which have elected to provide coverage under section 2111.

''(3) USE OF ADDITIONAL ALLOTMENT.—Additional allotments provided under this subsection are not available for amounts expended before October 1, 2002. Such amounts are available for amounts expended on or after such date for child health assistance for targeted low-income children, as well as for FamilyCare assistance.

''(4) REQUIRING ELECTION TO PROVIDE FAMILYCARE COVERAGE.—No payments may be made to a State under this title from an allotment provided under this subsection unless the State has made an election to provide FamilyCare assistance.''.

(ii) CONFORMING AMENDMENTS.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(I) in subsection (a), by inserting ''subject to subsection (d),'' after ''under this section,'';

(II) in subsection (b)(1), by inserting ''and subsection (d)'' after ''Subject to paragraph (4)''; and

(III) in subsection (c)(1), by inserting ''subject to subsection (d),'' after ''for a fiscal year,''.

(C) NO COST-SHARING FOR PREGNANCY-RELATED BENEFITS.—Section 2103(e)(2) of the Social Security Act (42 U.S.C. 1397cc(e)(2)) is amended—

(i) in the heading, by inserting ''AND PREGNANCY-RELATED SERVICES'' after ''PREVENTIVE SERVICES''; and

(ii) by inserting before the period at the end the following: ''and for pregnancy-related services''.

(3) EFFECTIVE DATE.—The amendments made by this subsection apply to items and services furnished on or after October 1, 2003, whether or not

regulations implementing such amendments have been issued.

(b) RULES FOR IMPLEMENTATION BEGINNING WITH FISCAL YEAR 2006.—

(1) REQUIRED COVERAGE OF FAMILYCARE PARENTS.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by striking the semicolon at the end of subclause (VII) and insert '', or''; and

(C) by adding at the end the following:

''(VIII) who are described in subsection (k)(1) (or would be described if subparagraph (A)(ii) of such subsection did not apply) and who are in families with incomes that do not exceed 100 percent of the poverty line applicable to a family of the size involved;''.

(2) EXPANSION OF AVAILABILITY OF ENHANCED MATCH UNDER MEDICAID FOR PRE-CHIP EXPANSIONS.—Paragraph (4) of section 1905(u) of

the Social Security Act (42 U.S.C. 1396d(u)), as inserted by subsection (a)(1)(C), is amended—

(A) by amending clause (ii) of subparagraph (A) to read as follows:

''(ii) CERTAIN PREGNANT WOMEN.—Expenditures for medical assistance for pregnant women under section 1902(l)(1)(A) in a family the income of which exceeds the 133 percent of the income official poverty line.''; and

(B) by adding at the end the following:

''(B) CHILDREN IN FAMILIES WITH INCOME ABOVE MEDICAID MANDATORY LEVEL NOT PREVIOUSLY DESCRIBED.—The expenditures described in this subparagraph are expenditures (other than expenditures described in paragraph (2) or (3)) for medical assistance made available to any child who is eligible for assistance under section 1902(a)(10)(A) (other than under clause (i)) and the income of whose family exceeds the minimum income level required under subsection 1902(l)(2) (or, if higher, the minimum level required under section 1931 for that State) for a child of the age involved (treating any child who is 19 or 20 years of age as being 18 years of age).''.

(3) OFFSET OF ADDITIONAL EXPENDITURES FOR ENHANCED MATCH FOR PRE-CHIP EXPANSION; ELIMINATION OF OFFSET FOR REQUIRED COVERAGE OF FAMILYCARE PARENTS.—

(A) IN GENERAL.—Section 1905(u)(5) of the Social Security Act (42 U.S.C. 1396d(u)(5)), as added by subsection (a)(1)(E), is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) REGULAR FMAP FOR EXPENDITURES FOR PREGNANT WOMEN WITH INCOME ABOVE 133 PERCENT OF POVERTY.—The portion of the payments made for expenditures described in paragraph (4)(A)(ii) that represents the amount that would have been paid if the enhanced FMAP had not been substituted for the Federal medical assistance percentage.''; and

(ii) by adding at the end the following:

''(B) FAMILYCARE PARENTS UNDER 100 PERCENT OF POVERTY.—Payments for expenditures described in paragraph (4)(A)(i) in the case of parents whose income does not exceed 100 percent of the in-

come official poverty line applicable to a family of the size involved.

''(C) REGULAR FMAP FOR EXPENDITURES FOR CERTAIN CHILDREN IN FAMILIES WITH INCOME ABOVE MEDICAID MANDATORY LEVEL.—The portion of the payments made for expenditures described in paragraph (4)(B) that represents the amount that would have been paid if the enhanced FMAP had not been substituted for the Federal medical assistance percentage.''.

(B) CONFORMING AMENDMENTS.—Subparagraph (B) of section 2105(a)(1) of the Social Security Act, as amended by section 217(a) and subsection (a)(1)(D), is amended to read as follows:

''(B) CERTAIN FAMILYCARE PARENTS AND OTHERS.—Expenditures for medical assistance that is attributable to expenditures described in section 1905(u)(4), except as provided in section 1905(u)(5).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection apply as of October 1, 2005, to fiscal years beginning on or after such date and to expenditures under the State plan on and after such

date, whether or not regulations implementing such amendments have been issued.

(c) MAKING TITLE XXI BASE ALLOTMENTS PERMANENT.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) by striking ''and'' at the end of paragraph (9);

(2) by striking the period at the end of paragraph (10) and inserting ''; and''; and

(3) by adding at the end the following:

''(11) for fiscal year 2009 and each fiscal year thereafter, the amount of the allotment provided under this subsection for the preceding fiscal year increased by the percentage increase (if any) in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average).''.

(d) OPTIONAL APPLICATION OF PRESUMPTIVE ELIGIBILITY PROVISIONS TO PARENTS.—Section 1920A of the Social Security Act (42 U.S.C. 1396r–1a) is amended by adding at the end the following:

''(e) A State may elect to apply the previous provisions of this section to provide for a period of presumptive eligibility for medical assistance for a parent (as defined

for purposes of section 1902(k)(1)) of a child with respect to whom such a period is provided under this section.''.

(e) CONFORMING AMENDMENTS.—

(1) ELIGIBILITY CATEGORIES.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended, in the matter before paragraph (1)—

(A) by striking ''or'' at the end of clause (xii);

(B) by inserting ''or'' at the end of clause (xiii); and

(C) by inserting after clause (xiii) the following:

''(xiv) who are parents described (or treated as if described) in section 1902(k)(1),''.

(2) INCOME LIMITATIONS.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(A) effective October 1, 2005, by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''; and

(B) by inserting ''1902(a)(10)(A)(ii)(XIX),'' after ''1902(a)(10)(A)(ii)(XVIII),''.

(3) CONFORMING AMENDMENT RELATING TO NO WAITING PERIOD FOR PREGNANT WOMEN.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) by striking ", and" at the end of clause (i) and inserting a semicolon;

(B) by striking the period at the end of clause (ii) and inserting "; and"; and

(C) by adding at the end the following:

"(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income parent who is pregnant.".

SEC. 213. OPTIONAL COVERAGE OF CHILDREN THROUGH AGE 20 UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) MEDICAID.—

(1) IN GENERAL.—Section 1902(l)(1)(D) of the Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting "(or, at the election of a State, 20 or 21 years of age)" after "19 years of age".

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(e)(3)(A) of the Social Security Act (42 U.S.C. 1396a(e)(3)(A)) is

amended by inserting ''(or 1 year less than the age the State has elected under subsection (l)(1)(D))'' after ''18 years of age''.

(B) Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended by inserting ''or such higher age as the State has elected under subsection (l)(1)(D)'' after ''19 years of age''.

(C) Section 1920A(b)(1) of the Social Security Act (42 U.S.C. 1396r–1a(b)(1)) is amended by inserting ''or such higher age as the State has elected under section 1902(l)(1)(D)'' after ''19 years of age''.

(D) Section 1928(h)(1) of the Social Security Act (42 U.S.C. 1396s(h)(1)) is amended by inserting ''or 1 year less than the age the State has elected under section 1902(l)(1)(D)'' before the period at the end.

(E) Section 1932(a)(2)(A) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)(A)) is amended by inserting ''(or such higher age as the State has elected under section 1902(l)(1)(D))'' after ''19 years of age''.

(b) TITLE XXI.—Section 2110(c)(1) of the Social Security Act (42 U.S.C. 1397jj(c)(1)) is amended by in-

serting ''(or such higher age as the State has elected under section 1902(l)(1)(D))''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003, and apply to medical assistance and child health assistance provided on or after such date, whether or not regulations implementing such amendments have been issued.

SEC. 214. INCREASE IN CHIP ALLOTMENT FOR EACH OF FISCAL YEARS 2002 THROUGH 2004.

Paragraphs (5), (6), and (7) of section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) are amended by striking ''$3,150,000,000'' each place it appears and inserting ''$4,150,000,000''.

SEC. 215. ADDITIONAL CHIP REVISIONS.

(a) LIMITING COST-SHARING TO 2.5 PERCENT FOR FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY.—Section 2103(e)(3)(A) of the Social Security Act (42 U.S.C. 1397cc(e)(3)(A)) is amended—

(1) by striking ''and'' at the end of clause (i);

(2) by striking the period at the end of clause (ii) and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(iii) total annual aggregate cost-sharing described in clauses (i) and (ii)

with respect to all such targeted low-income children in a family under this title that exceeds 2.5 percent of such family's income for the year involved.''.

(b) REPORTING OF ENROLLMENT DATA.—

(1) QUARTERLY REPORTS.—Section 2107(b)(1) of such Act (42 U.S.C. 1397gg(b)(1)) is amended by adding at the end the following: ''In quarterly reports on enrollment required under this paragraph, a State shall include information on the age, gender, race, ethnicity, service delivery system, and family income of individuals enrolled.''.

(2) ANNUAL REPORTS.—Section 2108(b)(1)(B)(i) of such Act (42 U.S.C. 1397hh(b)(1)(B)(i)) is amended by inserting ''primary language of enrollees,'' after ''family income,''.

(c) EMPLOYER COVERAGE WAIVER CHANGES.—Section 2105(c)(3) of such Act (42 U.S.C. 1397ee(c)(3)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii) and indenting appropriately;

(2) by designating the matter beginning with ''Payment may be made'' as a subparagraph (A)

with the heading ''IN GENERAL'' and indenting appropriately;

(3) in subparagraph (A) (as so designated)—

(A) in the matter preceding clause (i) (as redesignated by paragraph (1)), by striking ''targeted low-income children'' and inserting ''a targeted low-income child, a targeted low-income parent, or a pregnant woman who is treated as a targeted low-income parent under section 2111(b)(4)'';

(B) in clause (i) (as so redesignated), by striking ''children'' and inserting ''child, targeted low-income parent, or pregnant woman treated as such a parent''; and

(C) in clause (ii) (as so redesignated), by striking ''children'' and inserting ''child, parent, or pregnant women''; and

(4) by adding at the end the following new subparagraphs:

''(B) APPLICATION OF REQUIREMENTS.—In carrying out subparagraph (A)—

''(i) the Secretary shall not require a minimum employer contribution level that is separate from the requirement of cost-effectiveness under subparagraph (A)(i),

but a State shall identify a reasonable minimum employer contribution level that is based on data demonstrating that such a level is representative to the employer-sponsored insurance market in the State and shall monitor employer contribution levels over time to determine whether substitution is occurring and report the findings in annual reports under section 2108(a);

''(ii) the State shall establish a waiting period of at least 6 months without group health coverage, but may establish reasonable exceptions to such period and shall not apply such a waiting period to a child who is provided coverage under a group health plan under section 1906;

''(iii) subject to clause (iv), the State shall provide satisfactory assurances that the minimum benefits and cost-sharing protections established under this title are provided, either through the coverage under subparagraph (A) or as a supplement to such coverage; and

''(iv) coverage under such subparagraph shall not be considered to violate clause (iii) because it does not comply with requirements relating to reviews of health service decisions if the enrollee involved is provided the option of being provided benefits directly under this title.

''(C) ACCESS TO EXTERNAL REVIEW PROCESS.—In carrying out subparagraph (A), if a State provides coverage under a group health plan that does not meet the following external review requirements, the State must give applicants and enrollees (at initial enrollment and at each redetermination of eligibility) the option to obtain health benefits coverage other than through that group health plan:

''(i) The enrollee has an opportunity for external review of a—

''(I) delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and

''(II) failure to approve, furnish, or provide payment for health services in a timely manner.

''(ii) The external review is conducted by the State or a impartial contractor other than the contractor responsible for the matter subject to external review.

''(iii) The external review decision is made on a timely basis in accordance with the medical needs of the patient. If the medical needs of the patient do not dictate a shorter time frame, the review must be completed—

''(I) within 90 calendar days of the date of the request for internal or external review; or

''(II) within 72 hours if the enrollee's physician or plan determines that the deadline under subclause (I) could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function (except that a State may extend the 72-hour deadline by up to 14 days if the enrollee requests an extension).

''(iv) The external review decision shall be in writing.

''(v) Applicants and enrollees have an opportunity—

''(I) to represent themselves or have representatives of their choosing in the review process;

''(II) timely review their files and other applicable information relevant to the review of the decision; and

''(III) fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process.''.

(d) SENSE OF THE SENATE REGARDING AUTHORITY TO USE SCHIP FUNDS TO PURCHASE FAMILY COVERAGE.—It is the sense of the Senate that section 2105(c)(3) of the Social Security Act (42 U.S.C. 1397ee(c)(3)) permits States to use funds provided under the State children's health insurance program established under title XXI of that Act (42 U.S.C. 1397aa et seq.) to help low-income working families and pregnant women

eligible for assistance under that program pay their share of employer-sponsored health insurance coverage.

(e) EFFECTIVE DATE.—The amendments made by this section apply as of October 1, 2003, whether or not regulations implementing such amendments have been issued.

SEC. 216. LIMITATIONS ON CONFLICTS OF INTEREST.

(a) LIMITATION ON CONFLICTS OF INTEREST IN MARKETING ACTIVITIES.—

(1) TITLE XXI.—Section 2105(c) of the Social Security Act (42 U.S.C. 300aa–5(c)) is amended by adding at the end the following:

''(8) LIMITATION ON EXPENDITURES FOR MARKETING ACTIVITIES.—Amounts expended by a State for the use of an administrative vendor in marketing health benefits coverage to low-income children under this title shall not be considered, for purposes of subsection (a)(2)(D), to be reasonable costs to administer the plan unless the following conditions are met with respect to the vendor:

''(A) The vendor is independent of any entity offering the coverage in the same area of the State in which the vendor is conducting marketing activities.

''(B) No person who is an owner, employee, consultant, or has a contract with the vendor either has any direct or indirect financial interest with such an entity or has been excluded from participation in the program under this title or title XVIII or XIX or debarred by any Federal agency, or subject to a civil money penalty under this Act.''.

(b) PROHIBITION OF AFFILIATION WITH DEBARRED INDIVIDUALS.—

(1) MEDICAID.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i))is amended—

(A) by striking the period at the end of paragraph (20) and inserting ''; or''; and

(B) by inserting after paragraph (20) the following:

''(21) with respect to any amounts expended for an entity that receives payments under the plan unless—

''(A) no person with an ownership or control interest (as defined in section 1124(a)(3)) in the entity is a person that is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement ac-

tivities under the Federal Acquisition Regulation; and

''(B) such entity has not entered into an employment, consulting, or other agreement for the provision of items or services that are material to such entity's obligations under the plan with a person described in subparagraph (A).''.

(2) TITLE XXI.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) in subparagraph (B), by striking ''and (17)'' and inserting ''(17), and (21)''; and

(B) by adding at the end the following:

''(E) Section 1902(a)(67) (relating to prohibition of affiliation with debarred individuals).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to expenditures made on or after October 1, 2003, whether or not regulations implementing such amendments have been issued.

SEC. 217. TECHNICAL AND CONFORMING AMENDMENTS TO AUTHORITY TO PAY MEDICAID EXPANSION COSTS FROM TITLE XXI APPROPRIATION.

(a) AUTHORITY TO PAY MEDICAID EXPANSION COSTS FROM TITLE XXI APPROPRIATION.—Section

2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)) is amended to read as follows:

''(a) ALLOWABLE EXPENDITURES.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104, an amount for each quarter equal to the enhanced FMAP of the following expenditures in the quarter:

''(A) CHILD HEALTH ASSISTANCE UNDER MEDICAID.—Expenditures for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for expenditures described in the fourth sentence of section 1905(b).

''(B) RESERVED.—[reserved].

''(C) CHILD HEALTH ASSISTANCE UNDER THIS TITLE.—Expenditures for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103.

''(D) ASSISTANCE AND ADMINISTRATIVE EXPENDITURES SUBJECT TO LIMIT.—Expendi-

tures only to the extent permitted consistent with subsection (c)—

"(i) for other child health assistance for targeted low-income children;

"(ii) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

"(iii) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

"(iv) for other reasonable costs incurred by the State to administer the plan.

"(2) ORDER OF PAYMENTS.—Payments under a subparagraph of paragraph (1) from a State's allotment for expenditures described in each such subparagraph shall be made on a quarterly basis in the order of such subparagraph in such paragraph.

"(3) NO DUPLICATIVE PAYMENT.—In the case of expenditures for which payment is made under paragraph (1), no payment shall be made under title XIX.".

(b) CONFORMING AMENDMENTS.—

(1) SECTION 1905(u).—Section 1905(u)(1)(B) of the Social Security Act (42 U.S.C. 1396d(u)(1)(B)) is amended by inserting ''and section 2105(a)(1)'' after ''subsection (b)''.

(2) SECTION 2105(c).—Section 2105(c)(2)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(2)(A)) is amended by striking ''subparagraphs (A), (C), and (D) of''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 251), whether or not regulations implementing such amendments have been issued.

Subtitle C—Simplified Enrollment

SEC. 221. AUTOMATIC ENROLLMENT OF CHILDREN BORN TO TITLE XXI PARENTS.

Section 2102(b)(1) of the Social Security Act (42 U.S.C. 1397bb(b)(1)) is amended by adding at the end the following:

''(C) AUTOMATIC ELIGIBILITY OF CHILDREN BORN TO A PARENT BEING PROVIDED FAMILYCARE.—Such eligibility standards shall provide for automatic coverage of a child born to an individual who is provided assistance under this title in the same manner as medical

assistance would be provided under section 1902(e)(4) to a child described in such section.''.

SEC. 222. APPLICATION OF SIMPLIFIED TITLE XXI PROCEDURES UNDER THE MEDICAID PROGRAM.

(a) APPLICATION UNDER MEDICAID.—

(1) IN GENERAL.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended—

(A) in paragraph (3), by inserting ''subject to paragraph (5)'', after ''Notwithstanding subsection (a)(17),''; and

(B) by adding at the end the following:

''(5) With respect to determining the eligibility of individuals under 19 years of age (or such higher age as the State has elected under paragraph (1)(D)) for medical assistance under subsection (a)(10)(A) and, separately, with respect to determining the eligibility of individuals for medical assistance under subsection (a)(10)(A)(i)(VIII) or (a)(10)(A)(ii)(XIX), notwithstanding any other provision of this title, if the State has established a State child health plan under title XXI—

''(A) the State may not apply a resource standard;

''(B) the State shall use the same simplified eligibility form (including, if applicable, permitting ap-

plication other than in person) as the State uses under such State child health plan with respect to such individuals;

''(C) the State shall provide for initial eligibility determinations and redeterminations of eligibility using verification policies, forms, and frequency that are no less restrictive than the policies, forms, and frequency the State uses for such purposes under such State child health plan with respect to such individuals; and

''(D) the State shall not require a face-to-face interview for purposes of initial eligibility determinations and redeterminations unless the State requires such an interview for such purposes under such child health plan with respect to such individuals.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to determinations of eligibility made on or after the date that is 1 year after the date of enactment of this Act, whether or not regulations implementing such amendments have been issued.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Section 1920A(b)(3)(A)(i) of the Social Security Act (42 U.S.C. 1396r–1a(b)(3)(A)(i)) is amended by inserting ''a child care

resource and referral agency,'' after ''a State or tribal child support enforcement agency,''.

(2) APPLICATION TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) of the Social Security Act (42 U.S.C. 1396r–1(b)) is amended by adding at the end after and below paragraph (2) the following flush sentence:

''The term 'qualified provider' includes a qualified entity as defined in section 1920A(b)(3).''.

(3) APPLICATION UNDER TITLE XXI.—

(A) IN GENERAL.—Section 2107(e)(1)(D) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

''(D) Sections 1920 and 1920A (relating to presumptive eligibility).''.

(B) CONFORMING ELIMINATION OF RESOURCE TEST.—Section 2102(b)(1)(A) of such Act (42 U.S.C. 1397bb(b)(1)(A)) is amended—

(i) by striking '' and resources (including any standards relating to spenddowns and disposition of resources)''; and

(ii) by adding at the end the following: ''Effective 1 year after the date of

enactment of the Access to Affordable Health Care Act, such standards may not include the application of a resource standard or test.''.

(c) AUTOMATIC REASSESSMENT OF ELIGIBILITY FOR TITLE XXI AND MEDICAID BENEFITS FOR CHILDREN LOSING MEDICAID OR TITLE XXI ELIGIBILITY.—

(1) LOSS OF MEDICAID ELIGIBILITY.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking the period at the end of paragraph (65) and inserting ''; and'', and

(B) by inserting after paragraph (65) the following:

''(66) provide, in the case of a State with a State child health plan under title XXI, that before medical assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XXI shall be made and, if determined to be so eligible, the child (or parent) shall be automatically enrolled in the program under such title without the need for a new application.''.

(2) LOSS OF TITLE XXI ELIGIBILITY AND COORDINATION WITH MEDICAID.—Section 2102(b) (42 U.S.C. 1397bb(b)) is amended—

(A) in paragraph (3), by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (C) the following:

''(D) that before health assistance to a child (or a parent of a child) is discontinued under this title, a determination of whether the child (or parent) is eligible for benefits under title XIX is made and, if determined to be so eligible, the child (or parent) is automatically enrolled in the program under such title without the need for a new application;'';

(B) by redesignating paragraph (4) as paragraph (5); and

(C) by inserting after paragraph (3) the following new paragraph:

''(4) COORDINATION WITH MEDICAID.—The State shall coordinate the screening and enrollment of individuals under this title and under title XIX consistent with the following:

''(A) Information that is collected under this title or under title XIX which is needed to

make an eligibility determination under the other title shall be transmitted to the appropriate administering entity under such other title in a timely manner so that coverage is not delayed and families do not have to submit the same information twice. Families shall be provided the information they need to complete the application process for coverage under both titles and be given appropriate notice of any determinations made on their applications for such coverage.

''(B) If a State does not use a joint application under this title and such title, the State shall—

''(i) promptly inform a child's parent or caretaker in writing and, if appropriate, orally, that a child has been found likely to be eligible under title XIX;

''(ii) provide the family with an application for medical assistance under such title and offer information about what (if any) further information, documentation, or other steps are needed to complete such application process;

''(iii) offer assistance in completing such application process; and

''(iv) promptly transmit the separate application under this title or the information obtained through such application, and all other relevant information and documentation, including the results of the screening process, to the State agency under title XIX for a final determination on eligibility under such title.

''(C) Applicants are notified in writing of—

''(i) benefits (including restrictions on cost-sharing) under title XIX; and

''(ii) eligibility rules that prohibit children who have been screened eligible for medical assistance under such title from being enrolled under this title, other than provisional temporary enrollment while a final eligibility determination is being made under such title.

''(D) If the agency administering this title is different from the agency administering a State plan under title XIX, such agencies shall

coordinate the screening and enrollment of applicants for such coverage under both titles.

''(E) The coordination procedures established between the program under this title and under title XIX shall apply not only to the initial eligibility determination of a family but also to any renewals or redeterminations of such eligibility.''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) apply to individuals who lose eligibility under the medicaid program under title XIX, or under a State child health insurance plan under title XXI, respectively, of the Social Security Act on or after October 1, 2003 (or, if later, 60 days after the date of enactment of this Act), whether or not regulations implementing such amendments have been issued.

(d) PROVISION OF MEDICAID AND CHIP APPLICATIONS AND INFORMATION UNDER THE SCHOOL LUNCH PROGRAM.—Section 9(b)(2)(B) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(2)(B)) is amended—

(1) by striking ''(B) Applications'' and inserting ''(B)(i) Applications''; and

(2) by adding at the end the following:

''(ii)(I) Applications for free and reduced price lunches that are distributed pursuant to clause (i) to parents or guardians of children in attendance at schools participating in the school lunch program under this Act shall also contain information on the availability of medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and of child health and FamilyCare assistance under title XXI of such Act, including information on how to obtain an application for assistance under such programs.

''(II) Information on the programs referred to in subclause (I) shall be provided on a form separate from the application form for free and reduced price lunches under clause (i).''.

(e) 12-MONTHS CONTINUOUS ELIGIBILITY.—

(1) MEDICAID.—Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended—

(A) by striking ''At the option of the State, the plan may'' and inserting ''The plan shall'';

(B) by striking ''an age specified by the State (not to exceed 19 years of age)'' and inserting ''19 years of age (or such higher age as the State has elected under subsection (l)(1)(D)) or, at the option of the State, who is

eligible for medical assistance as the parent of such a child''; and

(C) in subparagraph (A), by striking ''a period (not to exceed 12 months)'' and inserting ''the 12-month period beginning on the date''.

(2) TITLE XXI.—Section 2102(b)(2) of such Act (42 U.S.C. 1397bb(b)(2)) is amended by adding at the end the following: ''Such methods shall provide 12-months continuous eligibility for children under this title in the same manner that section 1902(e)(12) provides 12-months continuous eligibility for children described in such section under title XIX. If a State has elected to apply section 1902(e)(12) to parents, such methods may provide 12-months continuous eligibility for parents under this title in the same manner that such section provides 12-months continuous eligibility for parents described in such section under title XIX.''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by this subsection take effect on October 1, 2003 (or, if later, 60 days after the date of enactment of this Act), whether or not regulations

implementing such amendments have been issued.

SEC. 223. ELIMINATION OF 100 HOUR RULE AND OTHER AFDC-RELATED ELIGIBILITY RESTRICTIONS.

(a) IN GENERAL.—Section 1931(b)(1)(A)(ii) of the Social Security Act (42 U.S.C. 1396u–1(b)(1)(A)(ii)) is amended by inserting ''other than the requirement that the child be deprived of parental support or care by reason of the death, continued absence from the home, incapacity, or unemployment of a parent,'' after ''section 407(a),''.

(b) CONFORMING AMENDMENT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended, in the matter before paragraph (1), in clause (ii), by striking ''if such child is (or would, if needy, be) a dependent child under part A of title IV''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to eligibility determinations made on or after October 1, 2003, whether or not regulations implementing such amendments have been issued.

Subtitle D—State Option to Provide Coverage of Legal Immigrants Under Medicaid and SCHIP

SEC. 231. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) MEDICAID PROGRAM.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

(2) by adding at the end the following:

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within any of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

''(iii) PARENTS.—If the State has elected the eligibility category described in clause (ii), caretaker relatives who are parents (including individuals treated as a caregiver for purposes of carrying out section 1931) of children (described in such clause or otherwise) who are eligible for medical assistance under the plan.

''(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.''.

(b) TITLE XXI.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by section 216(b)(2), is amended by adding at the end the following:

''(F) Section 1903(v)(4) (relating to optional coverage of categories of lawful resident alien children and parents), but only with respect to an eligibility category under this title,

if the same eligibility category has been elected under such section for purposes of title XIX.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003, and apply to medical assistance and child health assistance furnished on or after such date, whether or not regulations implementing such amendments have been issued.

Subtitle E—State Option to Extend Medicaid Coverage to Certain Low-Income Individuals

SEC. 241. STATE OPTION TO EXTEND MEDICAID COVERAGE TO CERTAIN LOW-INCOME INDIVIDUALS.

(a) STATE OPTION.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 212(a)(1)(A), is amended—

(1) by striking ''or'' at the end of subclause (XVIII);

(2) by adding ''or'' at the end of subclause (XIX); and

(3) by adding at the end the following:

''(XX) who are individuals who are not otherwise eligible for medical assistance under this subparagraph, or under a waiver approved under section 1115, or otherwise, as of the date

of enactment of this subclause and whose family income does not exceed 125 percent of the income official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAL ASSISTANCE ELIGIBILITY CATEGORIES.—Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by section 212(e)(1), is amended in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xiii);

(ii) by adding ''or'' at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

''(xv) who are individuals described in section 1902(a)(10)(A)(ii)(XX),''.

(2) EXEMPTION FROM UPPER INCOME LIMITATION.—Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 212(e)(2)(B), is

amended by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

(c) EFFECTIVE DATES.—The amendments made by this subsection take effect on October 1, 2003.

Subtitle F—Improving Welfare-to-Work Transition Under Medicaid

SEC. 251. IMPROVING WELFARE-TO-WORK TRANSITION UNDER MEDICAID.

(a) MAKING PROVISION PERMANENT.—

(1) IN GENERAL.—Subsection (f) of section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is repealed.

(2) CONFORMING AMENDMENT.—Section 1902(e)(1) of the Social Security Act (42 U.S.C. 1396a(e)(1)) is repealed.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a), by adding at the end the following:

''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months).

In the case of such an election, subsection (b) shall not apply.''; and

(2) in subsection (b)(1), by inserting ''and subsection (a)(5)'' after ''paragraph (3)''.

(c) SIMPLIFICATION.—

(1) REMOVAL OF ADMINISTRATIVE REPORTING REQUIREMENTS FOR ADDITIONAL 6-MONTH EXTENSION.—Section 1925(b)(2) of the Social Security Act (42 U.S.C. 1396r–6(b)(2)) is amended—

(A) by striking subparagraph (B);

(B) in subparagraph (A)(i)—

(i) in the heading, by striking ''AND REQUIREMENTS'';

(ii) by striking ''(I)'' and all that follows through ''(II)'' and inserting ''(i)'';

(iii) by striking '', and (III)'' and inserting ''and (ii)''; and

(iv) by redesignating such subparagraph as subparagraph (A) (with appropriate indentation); and

(C) in subparagraph (A)(ii)—

(i) in the heading, by striking ''REPORTING REQUIREMENTS AND'';

(ii) by striking ''notify the family of the reporting requirement under subpara-

graph (B)(ii) and'' and inserting ''provide the family with notification of''; and

(iii) by redesignating such subparagraph as subparagraph (B) (with appropriate indentation).

(2) REMOVAL OF REQUIREMENT FOR PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of the Social Security Act (42 U.S.C. 1396r–6(a)(1)) is amended—

(A) by inserting ''but subject to subparagraph (B)'' after ''any other provision of this title'';

(B) by redesignating the matter after ''REQUIREMENT.—'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with the same indentation as subparagraph (B) (as added by subparagraph (C)); and

(C) by adding at the end the following:

''(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that had applied for and was eligible for such aid for fewer than 3

months during the 6 immediately preceding months described in such subparagraph.''.

(3) PERMITTING INCREASE OR WAIVER OF 185 PERCENT OF POVERTY EARNING LIMIT.—Section 1925(b)(3)(A)(iii)(III) of the Social Security Act (42 U.S.C. 1396r–6(b)(3)(A)(iii)(III)) is amended—

(A) by inserting ''(at its option)'' after ''the State''; and

(B) by inserting ''(or such higher percent as the State may specify)'' after ''185 percent''.

(4) EXEMPTION FOR STATES COVERING NEEDY FAMILIES UP TO 185 PERCENT OF POVERTY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6), as amended by subsection (a), is amended—

(A) in each of subsections (a)(1) and (b)(1), by inserting ''but subject to subsection (f),'' after ''Notwithstanding any other provision of this title,''; and

(B) by adding at the end the following:

''(f) EXEMPTION FOR STATE COVERING NEEDY FAMILIES UP TO 185 PERCENT OF POVERTY.—

''(1) IN GENERAL.—At State option, the provisions of this section shall not apply to a State that uses the authority under section

1902(a)(10)(A)(ii)(XIX), section 1931(b)(2)(C), or otherwise to make medical assistance available under the State plan under this title to eligibleindividuals described in section 1902(k)(1), or all individuals described in section 1931(b)(1), and who are in families with gross incomes (determined without regard to work-related child care expenses of such individuals) at or below 185 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(2) APPLICATION TO OTHER PROVISIONS OF THIS TITLE.—The State plan of a State described in paragraph (1) shall be deemed to meet the requirements of section 1902(a)(10)(A)(i)(I).''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003, whether or not regulations implementing such amendments have been issued.

Subtitle G—Demonstration Programs to Improve Medicaid and SCHIP Outreach to Homeless Individuals and Families

SEC. 261. DEMONSTRATION PROGRAMS TO IMPROVE MEDICAID AND SCHIP OUTREACH TO HOMELESS INDIVIDUALS AND FAMILIES.

(a) AUTHORITY.—The Secretary of Health and Human Services may award demonstration grants to not more than 7 States (or other qualified entities) to conduct innovative programs that are designed to improve outreach to homeless individuals and families under the programs described in subsection (b) with respect to enrollment of such individuals and families under such programs and the provision of services (and coordinating the provision of such services) under such programs.

(b) PROGRAMS FOR HOMELESS DESCRIBED.—The programs described in this subsection are as follows:

(1) MEDICAID.—The program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) CHIP.—The program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(3) TANF.—The program under part of A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(4) SAMHSA BLOCK GRANTS.—The program of grants under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–1 et seq.).

(5) FOOD STAMP PROGRAM.—The program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

(6) WORKFORCE INVESTMENT ACT.—The program under the Workforce Investment Act of 1999 (29 U.S.C. 2801 et seq.).

(7) WELFARE-TO-WORK.—The welfare-to-work program under section 403(a)(5) of the Social Security Act (42 U.S.C. 603(a)(5)).

(8) OTHER PROGRAMS.—Other public and private benefit programs that serve low-income individuals.

(c) APPROPRIATIONS.—For the purposes of carrying out this section, there is appropriated for fiscal year 2004, out of any funds in the Treasury not otherwise appropriated, $10,000,000, to remain available until expended.

Subtitle H—High Risk Pools

SEC. 271. PROMOTION OF STATE HIGH RISK POOLS.

Title XXVII of the Public Health Service Act is amended by inserting after section 2745 (42 U.S.C. 300gg-45) the following:

"SEC. 2746. PROMOTION OF QUALIFIED HIGH RISK POOLS.

''(a) SEED GRANTS TO STATES.—From amounts appropriate under subsection (c)(1), the Secretary shall award a grant of up to $1,000,000 to each State that has not created a qualified high risk pool as of the date of the enactment of this section for the State's costs of the creation and initial operation of such a pool.

''(b) MATCHING FUNDS FOR OPERATION OF POOLS.—

''(1) IN GENERAL.—In the case of a State that has established a qualified high risk pool that restricts premiums charged under the pool to no more than 150 percent of the premium for applicable standard risk rates and that offers a choice of two or more coverage options through the pool, from the amounts appropriated under subsection (c)(2) and allotted to the State under paragraph (2), the Secretary shall provide a grant to such State in an amount that does not exceed 50 percent of the losses incurred by the State in connection with the operation of the pool.

''(2) ALLOTMENT.—The amount appropriated under subsection (c)(2) for a fiscal year shall be made available to the States in accordance with a formula that is developed by the Secretary based

upon the number of uninsured individuals in the States.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a State from supplementing the funds made available under this subsection for the support and operation of a qualified high risk pool.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

''(1) $20,000,000 for fiscal year 2004 to carry out subsection (a); and

''(2) $40,000,000 for each of fiscal years 2004 and 2005.

Amounts appropriated under this subsection for a fiscal year shall remain available for obligation through the end of the following fiscal year.

''(d) LIMITATION.—Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

''(e) DEFINITIONS.—In this section:

''(1) QUALIFIED HIGH RISK POOL.—The term 'qualified high risk pool' has the meaning given such term in section 2744(c)(2);

''(2) STATE.—The term 'State' means any of the 50 States and the District of Columbia.''.

TITLE III—STRENGTHENING THE HEALTH CARE SAFETY NET

SEC. 301. INCREASE IN FUNDING FOR THE CONSOLIDATED HEALTH CENTERS PROGRAM.

It is the sense of the Senate that the amounts appropriated for consolidated health centers under section 330 of the Public Health Service Act (42 U.S.C. 254b) should be doubled over the 5-fiscal year period beginning with fiscal year 2004.

TITLE IV—EXPANSION OF ACCESS TO HEALTH CARE IN RURAL AND UNDERSERVED AREAS

Subtitle A—National Health Service Corps

SEC. 401. EXPANSION OF FUNDING.

It is the sense of the Senate that the amounts appropriated for National Health Service Corps under subpart II of part D of title III of the Public Health Service Act (42 U.S.C. 254d et seq.) should be doubled over the 5-fiscal year period beginning with fiscal year 2004 to assist in provide support for physicians, dentists, and other health care clinicians who serve in rural and inner city areas.

SEC. 402. LOAN REPAYMENT AND SCHOLARSHIP PROGRAMS.

Section 338C of the Public Health Service Act (42 U.S.C. 254m) is amended by adding at the end the following:

''(e) Notwithstanding any other provision of this title, periods of obligated service may be served and fulfilled on a part time basis if—

''(1) such part time service is agreed to by both the placement site or sites and the recipient of the scholarship or loan repayment; and

''(2) the recipient's total obligation is fulfilled.''.

Subtitle B—Tax Exclusion for National Health Service Corps Loan Repayment Recipients

SEC. 411. EXCLUSION FOR LOAN PAYMENTS UNDER NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.

(a) IN GENERAL.—Section 117 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(e) LOAN PAYMENTS UNDER NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.—Gross income shall not include any amount received under section 338B(g) of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received by an individual in taxable years beginning after December 31, 2002.

TITLE V—EXPANDED ACCESS TO AFFORDABLE LONG-TERM CARE

SEC. 501. TREATMENT OF PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 223 as section 224 and by inserting after section 221 the following new section:

"SEC. 223. PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount of eligible long-term care premiums (as defined in section 213(d)(10)) paid during the taxable year for coverage for the taxpayer, his spouse, and dependents under a qualified long-term care insurance contract (as defined in section 7702B(b)).

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the applicable percentage shall be determined in accordance with the following table based on the number of years of continuous coverage (as of the close of the taxable year) of the individual under any qualified long-term care insurance contracts (as defined in section 7702B(b)):

''If the number of years of continuous coverage is—	**The applicable long-term care percentage is—**
Less than 1	60
At least 1 but less than 2	70
At least 2 but less than 3	80
At least 3 but less than 4	90
At least 4	100.

''(2) SPECIAL RULES FOR INDIVIDUALS WHO HAVE ATTAINED AGE 55.—In the case of an individual who has attained age 55 as of the close of the taxable year, the following table shall be substituted for the table in paragraph (1).

''If the number of years of continuous coverage is—	**The applicable long-term care percentage is—**
Less than 1	70
At least 1 but less than 2	85
At least 2	100.

''(3) ONLY COVERAGE AFTER 2002 TAKEN INTO ACCOUNT.—Only coverage for periods after December 31, 2002, shall be taken into account under this subsection.

''(4) CONTINUOUS COVERAGE.—An individual shall not fail to be treated as having continuous cov-

erage if the aggregate breaks in coverage during any 1-year period are less than 60 days.

''(c) COORDINATION WITH OTHER DEDUCTIONS.—Any amount paid by a taxpayer for any qualified long-term care insurance contract to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 162(l) or 213(a).''.

(b) LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end ''; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by an employer to accident and health plans) is amended by striking subsection (c).

(c) CONFORMING AMENDMENTS.—

(1) Section 62(a) of the Internal Revenue Code of 1986 is amended by inserting after paragraph (18) the following new item:

"(19) PREMIUMS ON QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—The deduction allowed by section 223.".

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

"Sec. 223. Premiums on qualified long-term care insurance contracts.
"Sec. 224. Cross reference.".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2002.

(2) CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2003.

SEC. 502. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of

1986 (relating to nonrefundable personal credits) is amended by inserting after section 25B the following new section:

"SEC. 25C. CREDIT FOR TAXPAYERS WITH LONG-TERM CARE NEEDS.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable credit amount multiplied by the number of applicable individuals with respect to whom the taxpayer is an eligible caregiver for the taxable year.

''(2) APPLICABLE CREDIT AMOUNT.—For purposes of paragraph (1), the applicable credit amount shall be determined in accordance with the following table:

"For taxable years beginning in calendar year—	**The applicable credit amount is—**
2002	$1,000
2003	1,500
2004	2,000
2005	2,500
2006 or thereafter	3,000 .

''(b) LIMITATION BASED ON ADJUSTED GROSS INCOME.—

''(1) IN GENERAL.—The amount of the credit allowable under subsection (a) shall be reduced (but not below zero) by $100 for each $1,000 (or fraction thereof) by which the taxpayer's modified adjusted

gross income exceeds the threshold amount. For purposes of the preceding sentence, the term 'modified adjusted gross income' means adjusted gross income increased by any amount excluded from gross income under section 911, 931, or 933.

''(2) THRESHOLD AMOUNT.—For purposes of paragraph (1), the term 'threshold amount' means—

''(A) $150,000 in the case of a joint return, and

''(B) $75,000 in any other case.

''(3) INDEXING.—In the case of any taxable year beginning in a calendar year after 2002, each dollar amount contained in paragraph (2) shall be increased by an amount equal to the product of—

''(A) such dollar amount, and

''(B) the medical care cost adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins, determined by substituting 'August 2002' for 'August 1996' in subclause (II) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

''(c) DEFINITIONS.—For purposes of this section—

''(1) APPLICABLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'applicable individual' means, with respect to any taxable year, any individual who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in subparagraph (B) for a period—

''(i) which is at least 180 consecutive days, and

''(ii) a portion of which occurs within the taxable year.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the 39½ month period ending on such due date (or such other period as the Secretary prescribes) a physician (as so defined) has certified that such individual meets such requirements.

''(B) INDIVIDUALS WITH LONG-TERM CARE NEEDS.—An individual is described in this subparagraph if the individual meets any of the following requirements:

''(i) The individual is at least 6 years of age and—

''(I) is unable to perform (without substantial assistance from another individual) at least 3 activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

''(II) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least 1 activity of daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

''(ii) The individual is at least 2 but not 6 years of age and is unable due to a loss of functional capacity to perform (without substantial assistance from an-

other individual) at least 2 of the following activities: eating, transferring, or mobility.

''(iii) The individual is under 2 years of age and requires specific durable medical equipment by reason of a severe health condition or requires a skilled practitioner trained to address the individual's condition to be available if the individual's parents or guardians are absent.

''(2) ELIGIBLE CAREGIVER.—

''(A) IN GENERAL.—A taxpayer shall be treated as an eligible caregiver for any taxable year with respect to the following individuals:

''(i) The taxpayer.

''(ii) The taxpayer's spouse.

''(iii) An individual with respect to whom the taxpayer is allowed a deduction under section 151 for the taxable year.

''(iv) An individual who would be described in clause (iii) for the taxable year if section 151(c)(1)(A) were applied by substituting for the exemption amount an amount equal to the sum of the exemption amount, the standard deduction under section 63(c)(2)(C), and any additional stand-

ard deduction under section 63(c)(3) which would be applicable to the individual if clause (iii) applied.

''(v) An individual who would be described in clause (iii) for the taxable year if—

''(I) the requirements of clause (iv) are met with respect to the individual, and

''(II) the requirements of subparagraph (B) are met with respect to the individual in lieu of the support test of section 152(a).

''(B) RESIDENCY TEST.—The requirements of this subparagraph are met if an individual has as his principal place of abode the home of the taxpayer and—

''(i) in the case of an individual who is an ancestor or descendant of the taxpayer or the taxpayer's spouse, is a member of the taxpayer's household for over half the taxable year, or

''(ii) in the case of any other individual, is a member of the taxpayer's household for the entire taxable year.

"(C) SPECIAL RULES WHERE MORE THAN 1 ELIGIBLE CAREGIVER.—

"(i) IN GENERAL.—If more than 1 individual is an eligible caregiver with respect to the same applicable individual for taxable years ending with or within the same calendar year, a taxpayer shall be treated as the eligible caregiver if each such individual (other than the taxpayer) files a written declaration (in such form and manner as the Secretary may prescribe) that such individual will not claim such applicable individual for the credit under this section.

"(ii) NO AGREEMENT.—If each individual required under clause (i) to file a written declaration under clause (i) does not do so, the individual with the highest modified adjusted gross income (as defined in section 32(c)(5)) shall be treated as the eligible caregiver.

"(iii) MARRIED INDIVIDUALS FILING SEPARATELY.—In the case of married individuals filing separately, the determination under this subparagraph as to whether the

husband or wife is the eligible caregiver shall be made under the rules of clause (ii) (whether or not one of them has filed a written declaration under clause (i)).

''(d) IDENTIFICATION REQUIREMENT.—No credit shall be allowed under this section to a taxpayer with respect to any applicable individual unless the taxpayer includes the name and taxpayer identification number of such individual, and the identification number of the physician certifying such individual, on the return of tax for the taxable year.

''(e) TAXABLE YEAR MUST BE FULL TAXABLE YEAR.—Except in the case of a taxable year closed by reason of the death of the taxpayer, no credit shall be allowable under this section in the case of a taxable year covering a period of less than 12 months.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 6213(g)(2) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of subparagraph (K), by striking the period at the end of subparagraph (L) and inserting '', and'', and by inserting after subparagraph (L) the following new subparagraph:

''(M) an omission of a correct TIN or physician identification required under section

25C(d) (relating to credit for taxpayers with long-term care needs) to be included on a return.''.

(2) Section 6213(g)(2) of the Internal Revenue Code of 1986, as amended by section 303(g) of the Economic Growth and Tax Relief Reconciliation Act of 2001, is amended by striking ''and'' at the end of subparagraph (L), by striking the period at the end of subparagraph (M) and inserting '', and'', and by inserting after subparagraph (M) the following new subparagraph:

''(N) an omission of a correct TIN or physician identification required under section 25C(d) (relating to credit for taxpayers with long-term care needs) to be included on a return.''.

(3) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25B the following new item:

''Sec. 25C. Credit for taxpayers with long-term care needs.''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after December 31, 2002.

(2) SUBSECTION (b)(1).—The amendments made by subsection (b)(1) shall apply for the period beginning after December 31, 2002, and before January 1, 2005.

(3) SUBSECTION (b)(2).—The amendments made by subsection (b)(2) shall take effect on January 1, 2005.

SEC. 503. ADDITIONAL CONSUMER PROTECTIONS FOR LONG-TERM CARE INSURANCE.

(a) ADDITIONAL PROTECTIONS APPLICABLE TO LONG-TERM CARE INSURANCE.—Subparagraphs (A) and (B) of section 7702B(g)(2) of the Internal Revenue Code of 1986 (relating to requirements of model regulation and Act) are amended to read as follows:

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any contract if such contract meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 6A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 6A.

''(II) Section 6B (relating to prohibitions on limitations and exclusions).

''(III) Section 6C (relating to extension of benefits).

''(IV) Section 6D (relating to continuation or conversion of coverage).

''(V) Section 6E (relating to discontinuance and replacement of policies).

''(VI) Section 7 (relating to unintentional lapse).

''(VII) Section 8 (relating to disclosure), other than section 8F thereof.

''(VIII) Section 11 (relating to prohibitions against post-claims underwriting).

''(IX) Section 12 (relating to minimum standards).

''(X) Section 13 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation

protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(XII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(III) The provisions of section 8 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of September 2000).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.''.

(b) EXCISE TAX.—Paragraph (1) of section 4980C(c) of the Internal Revenue Code of 1986 (relating to requirements of model provisions) is amended to read as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 9 (relating to required disclosure of rating practices to consumer).''

''(ii) Section 14 (relating to application forms and replacement coverage).

''(iii) Section 15 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

''(iv) Section 22 (relating to filing requirements for marketing).

''(v) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(vi) Section 24 (relating to suitability).

''(vii) Section 29 (relating to standard format outline of coverage).

''(viii) Section 30 (relating to requirement to deliver shopper's guide).

The requirements referred to in clause (vi) shall not include those portions of the personal worksheet described in Appendix B relating to consumer protection requirements not imposed by section 4980C or 7702B.

''(B) MODEL ACT.—The following requirements of the model Act must be met:

"(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

"(ii) Section 6G (relating to outline of coverage).

"(iii) Section 6H (relating to requirements for certificates under group plans).

"(iv) Section 6I (relating to policy summary).

"(v) Section 6J (relating to monthly reports on accelerated death benefits).

"(vi) Section 7 (relating to incontestability period).

"(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(g)(2)(B).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to policies issued more than 1 year after the date of the enactment of this Act.

TITLE VI—PROMOTING HEALTHIER LIFESTYLES

SEC. 601. COMMUNITY PARTNERSHIPS TO PROMOTE HEALTHY LIFESTYLES.

(a) GRANTS.—The Secretary of Health and Human Services (referred to in this title as the ''Secretary'') shall award grants to States to enable such States to provide assistance to eligible community partnerships that will carry out activities to promote healthy lifestyles.

(b) ELIGIBILITY.—

(1) STATE.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require.

(2) COMMUNITY PARTNERSHIP.—To be eligible to receive assistance from a State under a grant under subsection (a), an entity shall—

(A) be a partnership consisting of one or more public and private organizations (such as hospitals, health centers, other health care providers, employers, local educational agencies, community organizations, and public health organizations); and

(B) prepare and submit to the State an application at such time, in such manner and containing such information as the State may require, including a description of the activities that the partnership will carry out with assistance provided under this section.

(c) ACTIVITIES.—A State shall use amounts received under a grant under this section to support activities conducted by an eligible community partnership to promote health lifestyles, including—

(1) activities to reduce the primary risk factors for diseases, such as smoking, obesity, and sedentary lifestyles;

(2) implementing employee health promotion programs in the workplace using best practices to improve health access, education, and prevention promotion and disease management;

(3) activities to decrease hospital inpatient admissions of individuals with chronic diseases; and

(4) the development of programs relating to mental health and substance abuse.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2004 through 2006.

SEC. 602. WORKSITE WELLNESS GRANT PROGRAM.

(a) GRANTS.—The Secretary shall award grants to States (through State health departments or other State agencies working in consultation with the State health agency) to enable such States to provide assistance to employers that employ not to exceed 100 employees to enable such employers to establish and operate worksite wellness programs for their employees.

(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

(1) a description of the manner in which the State intends to use amounts received under the grant; and

(2) assurances that the State will only use amounts provided under such grant to provide assistance to employers that can demonstrate that they are in compliance with minimum program characteristics (relative to scope and regularity of services offered) that are developed by the Secretary in consultation with experts in public health and representatives of small employers.

(c) ALLOCATION.—Grants shall be allocated among States based on the population of individuals employed by small employers in such States.

(d) PROGRAM CHARACTERISTICS.—In developing minimum program characteristics under subsection (b)(2), the Secretary shall ensure that all activities established or enhanced under a grant under this section have clearly defined goals and objectives and demonstrate how receipt of such assistance will help to achieve established State or local health objectives based on the National Health Promotion and Disease Prevention Objectives.

(e) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used by a State to provide grants to employers (as described in subsection (a)), nonprofit organizations, or public authorities, or to operate State-based worksite wellness programs.

(f) SPECIAL EMPHASIS.—In funding employer worksite wellness projects under this section, a State shall give special emphasis to—

(1) the development of joint wellness programs between employers;

(2) the development of employee assistance programs dealing with substance abuse;

(3) maximizing the use of, and coordination with, existing community resources such as non-profit health organizations; and

(4) encouraging the participation of dependents of employees and retirees in wellness programs.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2004 through 2006.

SEC. 603. COMPREHENSIVE SCHOOL HEALTH EDUCATION.

(a) IN GENERAL.—The Secretary shall use amounts appropriated in each fiscal year under subsection (d) to expand comprehensive school health education programs administered by the Centers for Disease Control and Prevention under sections 301 and 311 of the Public Health Service Act (42 U.S.C. 241 and 243).

(b) SPECIFIED USE OF FUNDS.—In meeting the requirement of subsection (a), the Secretary shall expand the number of children receiving planned, sequential kindergarten through 12th grade comprehensive school education as a component of comprehensive programs of school health, including—

(1) physical education programs that provide lifelong physical activity;

(2) healthy school food service selections;

(3) programs that promote a healthy and safe school environment;

(4) schoolsite health promotion for faculty and staff;

(5) integrated school and community health promotion efforts; and

(6) school nursing disease prevention and health promotion services.

(c) COORDINATION OF EXISTING PROGRAMS.—The Secretary of Health and Human Services, the Secretary of Education, and the Secretary of Agriculture shall work cooperatively to coordinate existing school health education programs within the jurisdiction of their respective Departments in a manner that maximizes the efficiency and effectiveness of Federal expenditures for such programs.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2004 through 2006.

TITLE VII—MEDICARE FAIRNESS

Subtitle A—Medicare Value and Quality Demonstration

SEC. 701. FINDINGS.

The Senate makes the following findings:

(1) The United States Government should reward physicians, hospitals, and other health care providers that provide high-quality, cost-effective health care to beneficiaries under the medicare program.

(2) The Journal of the American Medical Association has published quality indicators in an article entitled ''Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels''.

(3) The cost of health care is—

(A) reflected in the type and volume of physicians' services and in physician ordering and prescribing behavior; and

(B) reflected in the amount of the average payment to hospitals under the medicare program for each medicare beneficiary in each State.

(4) Physician and hospital practice patterns contribute to the total cost and quality of care for each medicare beneficiary in each State.

(5) The original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act does not include a mechanism to pay for interventions designed to improve quality of

care. While the framework for payments to managed care organizations under the Medicare+Choice program under part C of such title allows for the reallocation of capitation revenues to cover such things as disease state management and quality improvement infrastructure, even the most optimistic projections for managed care enrollment leave the majority of medicare beneficiaries in the original medicare fee-for-service program.

SEC. 702. DEMONSTRATION PROJECT TO ENCOURAGE THE PROVISION OF HIGH-QUALITY, COST-EFFECTIVE INPATIENT HOSPITAL SERVICES.

(a) PURPOSE.—The purpose of the demonstration project conducted under this section is to encourage the provision of high-quality, cost-effective health care to beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) by providing incentive payments to hospitals located in States in which high-quality and cost-effective services are being provided in order to finance further quality improvements.

(b) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the

Secretary shall establish a demonstration project under which—

(A) the Secretary provides bonus payments to providers of inpatient hospital services that deliver high-quality health care at low costs in accordance with the methodology established by the Agency for Healthcare Research and Quality under paragraph (2); and

(B) the Secretary funds a plan at each site to increase the number of providers of inpatient hospital services that provide high-quality, low-cost health care to beneficiaries under the medicare program under title XVIII of the Social Security Act.

(2) VALUE AND QUALITY RANKING METHODOLOGY.—

(A) IN GENERAL.—The Agency for Healthcare Research and Quality shall establish a value and quality ranking methodology under which the Secretary awards bonus payments to providers of inpatient hospital services located in those States that demonstrate that such providers in the State are providing high value because of the high-quality, cost-effective health

care services being provided to medicare beneficiaries.

(B) BASIS.—The methodology established under subparagraph (A) shall be based on the rank and performance on medicare quality indicators contained in the article entitled ''Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels'' published in the October 4, 2000, issue of the Journal of the American Medical Association or such other quality indicators as the Secretary determines to be appropriate.

(3) SITES.—The Secretary shall select 2 States in which to conduct the demonstration project—

(A) from among the top 25 States (as ranked using the methodology established under paragraph (2)) that are also among the group of 25 States with the lowest per capita cost to the medicare program under title XVIII of the Social Security Act during the most recent 12-month period for which data are available; and

(B) based upon information contained in applications submitted to the Secretary by such States at such time, in such form and manner,

and containing such information as the Secretary may require.

(4) DURATION OF PROJECT.—The demonstration project shall be conducted over a 5-year period.

(c) REPORTS.—The Secretary shall submit to the appropriate committees of Congress interim reports on the demonstration project and a final report on the project within 6 months after the conclusion of the project together with recommendations for such legislative or administrative action as the Secretary determines appropriate.

(d) WAIVER.—The Secretary shall waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary to conduct the demonstration project under this section.

(e) DEFINITIONS.—In this section:

(1) PROVIDER OF INPATIENT HOSPITAL SERVICES.—The term ''provider of inpatient hospital services'' means any individual or entity that receives payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for providing an inpatient hospital service (as defined in section 1861(b) of such Act (42 U.S.C. 1395x(b))).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(f) FUNDING.—There are appropriated from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) such sums as the Secretary determines are necessary to conduct the demonstration project under this section.

SEC. 703. DEMONSTRATION PROJECT TO ENCOURAGE THE PROVISION OF HIGH-QUALITY, COST-EFFECTIVE PHYSICIANS' SERVICES.

(a) PURPOSE.—The purpose of the demonstration project conducted under this section is to encourage the provision of high-quality, cost-effective health care to beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) by providing incentive payments to physicians located in States in which high-quality and cost-effective services are being provided in order to finance further quality improvements.

(b) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall establish a demonstration project under which—

(A) the Secretary provides bonus payments to providers of physicians' services that deliver high-quality, cost-effective health care in accordance with the methodology established by the Agency for Healthcare Research and Quality under paragraph (2); and

(B) the Secretary funds a plan in each State to increase the number of providers of physicians' services that provide high-quality, cost-effective health care to beneficiaries under the medicare program under title XVIII of the Social Security Act.

(2) VALUE AND QUALITY RANKING METHODOLOGY.—

(A) IN GENERAL.—The Agency for Healthcare Research and Quality shall establish a value and quality ranking methodology under which the Secretary awards bonus payments to providers of physicians' services located in those States that demonstrate that such providers in the State are providing high value because of the high-quality, cost-effective health care services being provided to medicare beneficiaries.

(B) BASIS.—The methodology established under subparagraph (A) shall be based on the

rank and performance on medicare quality indicators contained in the article entitled ''Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels'' published in the October 4, 2000, issue of the Journal of the American Medical Association or such other quality indicators as the Secretary determines to be appropriate.

(3) SITES.—The Secretary shall select 2 States in which to conduct the demonstration project—

(A) from among the top 25 States (as ranked using the methodology established under paragraph (2)) that are also among the 25 States with the lowest per capita cost to the medicare program under title XVIII of the Social Security Act during the most recent 12-month period for which data are available; and

(B) based upon information contained in applications submitted to the Secretary by such States at such time, in such form and manner, and containing such information as the Secretary may require.

(4) DURATION OF PROJECT.—The demonstration project shall be conducted over a 5-year period.

(c) REPORTS.—The Secretary shall submit to the appropriate committees of Congress interim reports on the demonstration project and a final report on the project within 6 months after the conclusion of the project together with recommendations for such legislative or administrative action as the Secretary determines appropriate.

(d) WAIVER.—The Secretary shall waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary to conduct the demonstration project under this section.

(e) DEFINITIONS.—In this section:

(1) PROVIDER OF PHYSICIANS' SERVICES.—The term ''provider of physicians' services'' means any individual or entity that receives payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for providing physicians' services (as defined in section 1861(q) of such Act (42 U.S.C. 1395x(q))).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(f) FUNDING.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t)

such sums as the Secretary determines are necessary to conduct the demonstration project under this section.

Subtitle B—Graduate Medical Education Demonstration

SEC. 711. CLINICAL ROTATION DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall establish a demonstration project that provides for demonstration grants designed to provide financial or other incentives to hospitals to attract educators and clinical practitioners so that hospitals that serve beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who are residents of underserved areas may host clinical rotations.

(b) DURATION OF PROJECT.—The demonstration project shall be conducted over a 5-year period.

(c) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall pay the costs of the demonstration project conducted under this section from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(2) CAP ON FUNDING.—The Secretary may not expend more than $20,000,000 to conduct the demonstration project under this section.

(3) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under subsection (d)(5)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) for the indirect costs of medical education and for direct graduate medical education costs under subsection (h) of such section to reflect any increase in amounts expended from the Federal Hospital Insurance Trust Fund as a result of the demonstration project conducted under this section.

(d) REPORTS.—The Secretary shall submit to the appropriate committees of Congress interim reports on the demonstration project and a final report on such project within 6 months after the conclusion of the project together with recommendations for such legislative or administrative action as the Secretary determines appropriate.

(e) WAIVER.—The Secretary shall waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be nec-

essary to conduct the demonstration project under this section.

(f) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term ''hospital'' means any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) that had indirect or direct costs of medical education during the most recent cost reporting period preceding the date of enactment of this Act.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) UNDERSERVED AREA.—The term ''underserved area'' means such medically underserved urban areas and medically underserved rural areas as the Secretary may specify.

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